BRAC

BANGLADESH RURAL
ADVANCEMENT COMMITTEE

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SULLA PROJECT
REPORT ON PHASE II
November 1, 1972 - December 31, 1975

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GENESIS:

BRAC was formed in February 1972 in response to the humanitarian needs of Bangladesh following the widespread devastations of the 1971 Liberation struggle. It is wholly Bengali organization registered under the Societies Registration Act 1860. Presently BRAC is operating a number of development projects in Bangladesh, the largest of which, in scope and activities is the Sulla Project - an integrated rural development porject covering an area of 160 square miles in Sulla, Derai and Baniyachong Thanas of Sylhet District.

The Phase I rehabilitation programme covered a period from February to October 1972. It consisted of a large housing programme to replace the war destroyed houses (10,200 units) and repair of those in delapidated condition (3,900 units). BRAC also constructed 169 fishing boats and imported 4,500 lbs of Nylon twines for distribution to fisherman's cooperatives, To rehabilitate the returning agricultural refugees, seeds, fertiliser and cash loans were given. In addition BRAC provided medical care from 4 Rural Clinics and organized a Child Feeding programme in cooperation with *UNICEF to improve the nutrition condition then prevailing* in the project area.

REPORT ON SULLA PROJECT PHASE II

INTRODUCTION:

The report documents integrated development activities in the Sulla Project area during Phase II covering a period from October 1972 to December 1975. During this period BRAC was engaged in no less than eight major sectoral activities

organization, fisheries, functional education, community center construction, health care and family planning service delivery programme, vocational and other training programmes.

I. PROJECT AREA:

The area covered in the Sulla Project is located 24° north and 91° east, comprises the whole of Sulla Thana, 3 Unions of Derai Thana and 2 Unions in the Baniyachang Thana in Sylhet district. The project is comprised of 168 square miles of low lands over 90% of which is flooded during the monsoons. A population of approximately 120,000 live in 200 clustered villages barely higher than the monsoon water level. Though the population density of 700 per square mile is low for Bangladesh, (average 1,500 square mile) the habitable land is much more densely populated. The population is 65% Hindu and 35% Muslim. For adult males agriculture is the primary occupation with fishing a secondary occupation for most and primary occupation for 20% of the population.

The total cultivable land area is 64,000 acres of which 60,000 acres are one crop boro land (planted December-January) the rest of the land grows transplanted aman rice (planted in August/September). It is an excellent fishing area which abounds in lakes and rivers; fully 90% of the land is under water during the monsoon season.

Selection of the Sulla project area was made for a number of reasons. The area suffered rather severe devastation during the Liberation struggle; the area was quite poor before these events; and because of its inaccessibility the area was unlikely to get major relief support from most organizations. It is an area where ideas can be tested and developed.

ORGANIZATION AND PERSONNEL:

During Phase II period substantial changes were made in field organization to make it more responsive to the programme needs. The quality of multi-sectoral village level workers renamed as Field Motivator (FM) was upgraded by replacing a substantial number of non-graduate Field Assistants of the Phase I period by university graduates and Master degree holders. It was therefore, possible to transfer effective decision making from Area Managers to the Field Motivators.

To ensure proper supervision and coordination, the project area has been divided into 11 sectors (in place of 4 previously) under two zones. There are 42 Field Motivators each operating within a five village unit initiating and facilitating multi-sectoral activities. In addition to the FMs there are 30 paramedics providing curative and preventive health and family planning services. Each paramedic operates within an area of 6-7 villages with an average population of 5,000. There are an average of 4 Field Motivators and 3 paramedics operating in each sector and reporting to an Area Manager. The Area Managers report to one of the two Programme Coordinators, who in turn report to the Field Coordinator.

In order to free Area Managers from book keeping and accounting duties BRAC introduced a system of Travelling Accountants. Four travelling accountants headed by a Field Accountant make weekly rounds of the 11 field camps attending to cash disbursements, writing up books of accounts and updating Stock records.

Although BRAC organization is structured and authorities and responsibilities are carefully defined by organization chart, operating procedure etc., careful attention has been given to creating and maintaining staff motivation, dedication and commitment. Team spirit has been fostered through group dynamic sessions. Special training modules have been designed for this purpose. A spirit of coordination rather than competition has

and communication a weekly staff meeting is held in each of the eleven camps where past weeks activities are diaçussed and next weeks programme planned. A monthly meeting of Area Managers and Coordinators with the Executive Director has now been broadened to include all field staff. Two Zonal meetings attended by all field staff are now held for reviewing past months activities and for determining strategies and operating goals for the following month.

Throughout the Phase II period training programmes for imparting specific skills and upgrading the quality of Field staff and other programme personnel have been arranged within an outside BRAC. As a result of these, BRAC is in an enviable position of having a substantial group of highly motivated rural development workers who would make it possible for BRAC to expand its programmes. A full list of field staff and their educational background is set out below. BRAC organization chart is attached in the appendices for reference.

FIELD STAFF

Field Motivators	42	M.A./M.Sc.	22
Area Managers	11	B.A./B.Sc.	18
Programme Coordinators	2	Matriculates	16
Field Coordinators	1		
Paramedics	30	Matriculates	29
		Non-Matriculate	2
Doctors	4	M.B.B.S.	2
		National Diploma	2
Stores, Accountants, and Procurement Personnel	8	B.A./B.Com.	5
		Matriculate	2
Evaluation	2	M.Sc.	2
Workshop and Speedboat	2		
TOTAL	102		

FINANCING:

The original budgeted requirement of Taka 3,559,000 (U.S.$468,289) covering a period of 20 months was later revised and upward by Tk.476,606 to finance an extended Phase II period of 38 months to a revised total budget of Taka 4,035,606 (U.S.$531,000). The net total expenditure amounted to Taka 3,855,308 leaving an unspent balance of Taka 180,298 at the end of Phase II. Income and Expenditure Account covering the whole of Phase II period is given in the Appendices.

The programme was financed by OXFAM, Canada with contribution from Canadian International Development Agency, and OXFAM UK with participation from OXFAM American and Community Aid Abroad, Australia.

EVALUATION:

In order to assess affectiveness of BRAC programmes in theSulla project Area and more importantly, to determine the underlying factors responsible for success and failure of sectoral activities BRAC has undertaken a research and evaluation project which started from September, 1975. The Research and Evaluation design includes first the sample surveys for both overall assessment of field programmes and for specific sectoral activities such as functional education, agriculture, family planning. The second is the recruitment of three in-training economic anthropologist to undertake field work in the project area trained and supervised by an Anthropologist with broad experience, (possibly a consultant from overseas). The aim is to complement the quantitative approach of survey methodology with qualitative studies of social change that only in depth field observation can measure. The third is a systematic effort to streamline BRAC's record system so that input, output and service statistics could be generated. This project is designed to be carried out over a period of two years. It is estimated to Cost US $45,000 and has been funded by Ford Foundation.

GONOKENDRA (COMMUNITY CENTRE)

The programme for Phase II was the construction of 175 community centres in the larger villages of the project area, the villagers participated in this programme by donating land labour and part of cost of materials. The retionale behind this programme was to create a community facility at the village level for use by cooperative societies, Youth andWomen's organizations, and for holding adult education classes.

C.I. sheets and other building materials were issued for construction of 162 centres during Phase II. Initially, the high cost of timber forced BRAC and the villagers to construct all the centres with bamboo and C.I. sheets. The villagers provided the land, labour and part cost of materials and BRAC provided cost of materials, in the form of C.I. sheets and bamboo.

The initial bamboo structures could not withstand the pre-monsoon storms and a substantial number of them (81) were later reconstructed with timber supplied by BRAC at a nominal price. 20,000 cubic feet of timber logs were procured in Assam, India and floated down the river to the project site for sawing to different sizes to be used in Gonokendra construction. The cost of Assam timber worked out at one fifth of the local cost at the rate of Taka 15 per cubic feet.

Field personnel were initially too concerned with attaining construction targets without giving adequate attention to the objective of the programme. Gonokendra Committees were organized and construction work undertaken too hurriedly. As a result, some of the committees were found not to have the full confidence of the villagers and several of the construction sites were selected by the committees without due regard to the convenience of the majority of the villagers. Field workers were therefore, instructed not to be target oriented but to first develop participation of the entirely village in the Gonokendra programme before it was undertaken.

The Gonokendra construction in each village was an exciting

distinct community identification or feeling exist in the average Bangladesh village. Most villagers are divided into opposing factions, patronized and supported by the powerful families in the village to serve their exploitative interests. Despite these powerful factors where groups could be brought together for concerted action as a community, the Gonokendra construction was an exciting experience.

The new found community identity created an upsurge of community spirit in these villages. But this was not the case in at least one third of the villages where the programme faced intractable problems. Where no site is acceptable to all the factions and the Gonokendras constructed on temporary sites with bamboo are not being reconstructed with timber since all the factions can not agree to a single site. Consequently these are remaining unused and falling into disrepair. BRAC decided to withdraw C.I. sheets from these villages and have already made this decisions effective in 12 centres. The understanding is that if these villages wish to reconstruct their Gonokendra permanently, BRAC would reallocate C.I. sheets to them.

Despite the fact that this programme accounted for a substantial part of BRAC effort the achievement of the programs was not commensurate with the effort. With the benefit of hind sight BRAC feels that this programme should have been carried out on Phase III rather than Phase II. It was planned for implementation too early in the time frame i.e., programme implementation preceded the creation of felt need. As a result Gonokendra construction with people's participation proved to be more difficult than was anticipated.

FUNCTIONAL EDUCATION:

Since education plays a pivotal role in not only increasing awareness of problems but also the ways to solve them, it is an important part of BRAC's development effort.

The original Phase II Plan had envisaged eliminating illiteracy in Sulla within three years by conducting two courses a year in some 200 literacy centres. Although 255 literacy centers were opened, a high drop out rate, diminishing community interest, flood damage, and the inability of the communities to repair damaged centres resulted in the closure of more than half of the centres and the discontinuation of many others.

Realising the shortcomings of a purely academic adult literacy programme, BRAC recasted its approach away from teaching only literacy to imparting practical knowledge about matters of immediate concern to the learners. With the assistance of World Education of New York, BRAC undertook a project to develop a new teaching methodology and a new curriculum designed to make the learning process more interesting, informative and useful. "Teaching" was replaced by group discussion where the learners became the participants and the teachers assumed the role of moderator and guide who introduced new ideas and provided knowledge not possessed by the learners. The curriculum was developed by BRAC staff as the distillation of their collective experience in living amidst the learners in their community. Various teaching aids, such as charts and games were developed to create and retain the interest of the learners. Sulla was taken up as the testing ground for this project.

In keeping with the new approach, BRAC selected a limited number of centers, out of the original 255, where the new methodology could be introduced effectively. After screening 59. such centers were opened in May, 1974, each conducted by a parttime teacher recruited from the same community where the centre is located. The total initial enrollment in the First Cycle was 1,175 of which there were 734 men and 441 women learners. Classes t in the village community centres (Gonokendra) or homes.

The new approach generated the hoped for interest among the learners, teachers and BRAC's own field staff. There was a marked improvement in attendance and continuation. Drop out was mainly due to unavoidable reasons, such as migration of the learners to other areas, demands of planting the Boro crop the onset of seasonal inundation and personal reasons rather than declining learner interest. Out of the total initial and subsequent enrollment of 1,260 in the First Cycle 520 learners (41%) completed the entire eighty lessons course. In addition, there was a large number of learners who completed more than half of the course and thereby achieved some level of numeracy and literacy.

In the Second Cycle 53 centres were selected and initial enrollment was 1,087, when the course opened in June 1975*. By the end of January, 1976 these centres completed their course, graduating 591 learners (54%). As was the case in the First Cycle, there were a large number of learners in this cycle who also completed more than half the course, but could not remain to finish it.

Since this project is experimental, the development process is continuous. The experiences in the First Cycle brought out certain weaknesses and resulted in the modifications and improvements of the teaching method as well as the course content. The First Cycle course consisted of eighty lessons, of which 70% were core and the remaining 30% were designed to fulfill the special needs of the male and female learners. In the Second Cycle, it was reduced to seventy lessons, of which 14 were prepared separately for men and women learners. About half of the lessons were revised and a few were entirely dropped in the light of actual field experience. Moreover, many illus-

Training for Functional Education:

An integral part of BRAC's education programme is the training of the people who are going to implement it. Thus three categories of people were given training in Phase II.

1. Area Managers:

   Mr. Leon Clark of World Education who had worked in designing the Functional Education programme earlier, returned to Bangladesh in September, 1974 to train a core group of BRAC personnel who would subsequently train the field workers. Eleven Area Managers, members of Materials Development and other core staff attended this training course from 27 September to second October, 1974 in Dacca.

   The purpose of this training was to acquaint the Area Managers with the philosophy and teaching methodology of the programme.

2. Field Motivators;

   Immediately following the Managers' training in Dacca a five day course for the Field Motivators was conducted in Markuli. Thirtyfive FM's and 6 youths from various youth groups of Manikganj subdivision of Dacca District attended the training. The training was conducted by the Area Managers. Mr. Clark was also present.

3. Teachers:

   During the First Cycle, 61 teachers were trained in Markuli and Derai before the commencement of classes.

Initially, BRAC had planned to recruit only matriculates but there were few available in the area. Since it was considered more important to recruit teachers from the locality, the educational requirements were relaxed.

Before the commencement of the Second Cycle, the Area Managers attended a refresher course in Markuli, conducted by

the system. The full range of teachers training includes Methodological Training, Workshops, Follow-up Meetings and Refresher Courses.

Supervision and Evaluation:

In BRAC, supervision is not understood in its mechanical sense. Rather, it is a process to feed the needs of the programme for better performance.

It is an ongoing process involving all the Head Office and field staff responsible for the implementation of the programme. They monitor progress smooth out hitches, evaluate performance and collect statistical information.

Conclusion:

After a false start, the Functional Education programme has become one of the most effective of BRAC's programmes. It is still very much a pioneering, innovative and experimental project undergoing field testing and development. The signs, however, indicate that the approach has gained acceptance, interest and practical use in the lives of the learners.

AGRICULTURE:

Agriculture provides the livelihood for 82% of the population of Bangladesh, creates most of the national income and provides almost all its exports. Agriculture holds similar importance in our project area. Most of the land in the area is one crop Boro rice growing land which undergoes annual innundation during the monsoon. Agricultural activity is concentrated during the dry season from November to May. To improve agricultural productivity in the project area and to introduce cultivation of nutritionally advantageous crops, the main features of BRAC activities during the three agricultural seasons were as follows:

1. Agricultural Support Blocks:

Each season 20 to 30 agricultural support blocks with an average of 50 acres of land were taken for cultivating Hybrid Varieties of rice. 500-600 block farmers received day to day

support from our Field Motivators on procurement, dosage and application of fertilizer and insecticide, supply of seeds and constant supervision of their field activities. The support blocks were intended to provide demonstration effect on the best practices in rice growing by cultivators themselves with equipment and input within their means. Block farmers were brought into the planning process through regular meetings before the onset of the agricultural seasons, so that preparation for financing and procurement of inputs were taken well in advance to ensure delivery of supplies and services on time. Most of the block

members were able to procure their own supplies, but in some cases BRAC provided ferlizers on part credit. Support block farmers in most cases were able to show substantial improvement in yield.

Good quality seed rice of different HYVs were supplied at at cost to block farmers and others. Short duration varieties suitable for Boro season such as IRRATOM 24 and 38 and IRRI 176 were introduced which created great enthusiasm among farmers. Although IRRI 8 still remains the most popular HYV rice for Boro season due to its higher average yield, short duration varieties proved to be more suitable for comparatively low land where early on rush of monsoon water poses great risk.

2. Camp Demonstration Plots:

Each of the 11 BRAC camps organized their own demonstration plots completely worked by BRAC personnel. Average of 2 acres

were taken for rice or wheat demonstration and ½ acre for different varieties of vegetables by each team of BRAC workers living in field camps. Whilst these demonstration plots contributed to the method and result demonstration of different varieties of cereals and vegetables and facilitated agricultural extension activities of the BRAC staff, the most important dividend was that the BRAC established their credibility with the farmers as their equals. The sight of university graduates ploughing and transplanting brought laughter and sarcasm from villagers. The seriousness

one of respect. When the plants stood out as some of the best that they have seen grown in the area, the cultivators started asking for advice and requesting BRAC workers to visit their fields.

3. Input and Logistical Support of Landless and Women's Group

During each of the three agricultural sessons BRAC organized groups of landless laborers and destitute women for cultivation of fallow land leased from local landlords at nominal rental. BRAC provided all inputs and recovered the cost after harvesting. These groups received the services of BRAC power tillers and power pumps on a priority basis, and special care and attentionwas given by BRAC workers for success of these activities.

4. Vegetable Cultivation:

After three years of intensive extension and demonstration work vegetable gardening received wide acceptance in the project area. Vegetable seeds imported by Mennonite Central Committee were distributed each year to approximately 10,000 families in the project area - in addition to all primary and secondary schools. It is estimated 500 to 800 acres of land were put under vegetable cultivation by men, women and children each year. New vegetables such as Carrot, Broccoli, Chinese Cabbage were grown with great success alongside the traditionally grown Tomato, Cauliflower, Radishes etc. To create interest and enthuse growers, BRAC organized Horticultural Exhibitions in each camp and prizes were given to the growers of the best of each variety of vegetables.

In the first year of introduction, vegetables seeds were distributed free with instructions on seed bed preparation, transplantation and care of the plants. Vegetable seeds were sold to the growers in the subsequent years. Growers plots were regularly and repeatedly visited by BRAC workers to create interest and enthusiasm, and to provide advice and guidance.

Although vegetable seeds were not distributed free in the subsequent years no problems were encountered in selling the seeds. As a result of three years of successful demonstration and

have occurred in the dietary habits, which is bound to have an impact on the nutrition status of the population.

5. Low Lift Pump and Power Tiller Service:

BRAC procured 19 power pumps and 10 power tillers. The tillers were used for bringing fallow land under cultivation for the benefit of landless and other destitute groups. Small farmers lacking in draught animals were also provided power tillers service at a reasonable rental. Power pumps were hired to group of farmers for rice cultivation. BRAC workers were attached to each pump unit to ensure optimun use of power pumps and good water management. Average acreage irrigated by a 2 cusec power pump was over 52 acres, whereas the national average is under 20.

6. Food for Work Programme:

Apart from the substantial "Food for Work" programme undertaken during the dry season of 1974-75 to improve physical infrastructure, a number of small embankments, drainage and irrigation channels were excavated voluntarily by local people organized by the BRAC workers. During the early floods of April 1974, when the neighbouring areas suffered total destruction of their crop, the BRAC area only suffered a 40% crop loss due to the successful effort of the BRAC workers in mobilizing and activising entire villages for building dams and embankments day and night to fight the rising water.

During the agricultural slack seasons BRAC workers continued to provide extension services in horticulture. Papaya plantation undertaken in all the villages of the project area were destroyed in the unprecedented floods of 1974. BRAC transported thousands of different kinds of seedlings and distributed these at cost to interested villagers. Seedlings included coconut, bannana, mango, guava, etc.

BRAC has set up a small workshop in Markuli for repair and maintenance of its own agricultural machinery. Equipment for the workshop is on order from Singapore to expand the facilities with a view to extending these services to the general public.

COOPERATIVE:

Development of village and thana level cooperative institutions for generating concerted group action for rural development was one of the key programmes of Phase II in the Sulla project area. BRAC workers in the field have therefore put in tremenodus effort in the formation and development of cooperative organizations.

Most cooperative societies in Bangladesh are dominated and exploited by large landholders, money landers and other powerful elements in the village who act as the management committee of the society. Benefits accruing to the cooperative society such as input allocation, credit facility etc. are shared by the members of the managing group to the detriment of the members at large. Furthermore, corruption and misnanagement at the top, beset almost all the cooperative organizations. It is in the background that BRAC took up the cooperative development programme in the Sulla Project area.

In order to develop the existing primary societies BRAC felt that the first task was to eliminate corruption and unfair practices in these societies and restore members' interest in the societies affairs. All Field Motivators were trained in cooperative accounting practices and books of accounts of all the societies were updated, and regularly maintained. Members of cooperative societies were selected for training and on the job training was imparted. BRAC arranged with Government Cooperative Inspectors for audits and regular inspection of the societies state of affairs.

To restore members participation in the societies affairs regular weekly meetings of the societies were held. Field Motivators regularly attend these meetings where all aspects of societies affairs were discussed, savings were collected, activities were planned and during slack seasons, lessons from Functional Education suitable for cooperative members were given.

Farmers, fishermen, other traders and women's groups were organized into cooperatives. These groups were kept under observation for six months to assess their viability as a cooperative groups before registration were arranged with the cooperative department. BRAC provided inputs and credit facilities to these groups before registration were accorded to them. Care and attention was given in the composition of the management group, and wherever possible proportional representation of members in the management group was ensured.

BRAC supervisory staff were trained in cooperative institutes and the Academy for Rural Development in Comilla on cooperative principles and practices. They in turn provided training to all the field workers. 154 Chairmen and Secretaries of cooperative societies were given similar training by BRAC staff and extension officers of the cooperative department.

Annual General Meetins were arranged and new management committees were elected in a democratic manner. Members of cooperative societies were made aware of their rights, duties and obligations. Mismanagement and corruption greatly diminished and a new confidence in the cooperative movement began to emerge.

Cooperative societies in Sulla Thana decided to form the Sulla Thana Central Cooperative Association (STCCS). One of BRAC's local staff was elected the Secretary of the STCCA which received incorporation in May 1974. The STCCA decided to have union level associations in each of the four unions of Sulla Thana in order to decentralize some of its activities. The enthusiasm was great and the cost of land development was Tk.20,000 for STCC office in Ghungiargaon was locally financed. BRAC provided a grant to finance cost of STCCA books and stationery and the salar of the fulltime Secretary. But political interference within fou months of incorporation brought STCCA activities to a standstill which could be revived only after the change of Government in August 1975. The Government has now designated a Project Office

under Integrated Rural Development Programme to serve the STCCs. It has received fertilizer dealership for the Thana and have been provided with a credit of Tk.500,000 for disbursement to primary societies to meet the credit needs of members.

Four BRAC Field Camps/Cooperative Offices have been constructed and are now in use. Further construction required for union subcenters in Sulla Thana will hopefully be financed under the Government Programme.

In order to ensure continuous in-flow of leadership material with management abilities into the cooperative societies, youth organizers are being trained and developed. Groups of youth are being given support in community service activities such as village upkeep, maintenance of roads, bridges and culverts, child care and nutrition. BRAC field motivators are constantly providing guidance in youth activities.

Over 120 of farmers' fishermen and women, and landless peasants societies have been formed and are actively functioning. Although substantial progress has been made and the accumulated savings of these societies are in excess of Tk.200,000, BRAC feels that cooperative spirit has not yet taken a deep root in Sulla. Most cooperative societies activities still remain limited to the credit and input needs of members. Mobilization of broader range of resources for the benefit of the community at large still remains outside the perview of the most cooperative societies.

FISHERIES:

Fishing is the livelihood of 20% of the people in the project area which abounds in lakes, rivers and flood plains. Since fishing is a group activity requiring high capital inputs in nets, boats and Royalty payments, a number of Fishermen's cooperative existed before BRAC's arrival in Sulla area. These cooperatives were financed and exploited by non-fishermen money lenders who provided credits at usury rates of interest in addition to a share of the catch. As a result fishermen as a class remained one of the poorest and most exploited community.

The programme was to meet part of the input needs of fishermen so that the dependance on money lenders could be reduced. BRAC imported 10,000 lbs., of nylon twines for distribution to Fishermen Cooperatives. These were distributed to Fishermen societies at a nominal price of Tk.20.00 per lb.

Although Fishermen are one of the most exploited communities they in turn exploit their women. Net making is usually done by the women-folk of the Fishermen community and the rate of payment to women net makers is extremely low. In order to ensure that the women would receive a fair rate for net making, BRAC delivered the nylon twines to the women net making cooperatives who could charge a fair price for their labour.

In order to develop pisciculture in the project area, six large tanks were dug and a number of tanks were rehabilitated under the "Food for Work" programme. Nilotica fingerlings imported by UNICEF from Thailand was introduced. A number of Fishermen and youth group members were sent to Jamalpur for training in Nilotica culture.

In order to help individual fishermen in the slack monsoon season when organized fishing cannot be undertaken, 200,000 fish-hooks were imported from India and Singapore and distributed to the Fishermen. 15 medium sized fishing boats were built which await distribution pending a study of input requirements of the fishermen cooperatives.

BRAC feels that the programmes implemented so far have only had peripheral impact. Input requirement for fishermen's cooperati are so large that despite assistance from BRAC, the fishermen community still remains dependant on money lenders and the marketing operation still remains in the hands of middlemen. In order to extricate fishermen from these exploitative groups, a well planned capital intensive programme will be undertaken in Phas III.

TRAINING PROGRAMMES:

Vocational Training Centres for Women:

BRAC's programme was to establish four vocational training centres for training destitute women in a suitable skill to enable them to earn a subsistance income for themselves and their families.

One vocational training centre was established in Derai. Three batches numbering 89 women received training for three months in tailoring. UNICEF donated cloth for making children's garments and the trainees were able to utilize these by making clothing while they learnt. The children's clothing was sold at nominal prices to children.

Plans for another vocational training centre in weaving had to be abandoned due to the scarcity of cotton yarn in Bangladesh which made professional weavers unemployed.

BRAC felt that the training of women in skills which require assistance of male members in such matters as the procurement of raw materials, marketing of finished goods, etc., would not be the right approach for ensuring their economic independance. BRAC therefore, shifted its emphasis away from highly organized activities in which women in Bangladesh society are unable to function. More attention was given to developing social consciousness through functional education and formation and development of women's cooperatives and working groups.

As many as 30 women's cooperative societies have been organized for agriculture, horticulture, net making, tailoring etc. BRAC provided loans and other inputs to these cooperative societies. These societies are being encouraged to plan their own future activities with BRAC workers ready to provide whatever services they need.

Field Training Centre:

A Field Training centre was established at Markuli to provide training to:

(a) All levels of BRAC Field staff;

(b) Programme personnel such as Functional Education Teachers, Paramedical Workers etc;

(c) Cooperative, youth and women's organization members.

Apart from the training for BRAC staff and other programme personnel, training was provided to 130 youth and women organizers. A group of 9 development workers from Nabajagaran Shangshad in Dacca District and a group of 6 from the Gonomillan in Rajshahi District were given six months on-the-job training in community development. Two groups of 10 paramedics from Gono Unnayan Prochesta in Rajoir and from Rowmari TCCA were given BRAC paramedical training of four months duration.

Ford Foundation provided a training consultant who worked with BRAC training personnel on development of a set of highly innovative training modules suitable for development workers. These and other modules developed by our trainers are now being used very successfully in training development workers in various parts of Bangladesh.

MEDICAL CARE AND PUBLIC HEALTH:

This programme was designed to provide very accessible and low cost Health Services to the rural population of the Sulla project area. Delivery of Health Care was planned to be centered round a paramedic programme with Doctors available for training and referral services. Until the paramedics were trained and fielded, BRAC continued to operate the Four medical centres started in Phase I which provided medical care to out-patients at a token fee of Taka 0.30 per visit and partial cost of medicines.

Paramedical Training started in April 1973 with 21 trainees but was completed by only 11 in December 1973. They were given theoretical and practical training in Diagnosis and treatment of diseas prevelent in Bangladesh and received thorough grounding in nutrition child care, public health and family planning, Whenever possible the paramedical trainees were involved in BRAC programmes in other sectors such as agriculture, functional education, cooperatives etc. in order to develop their social consciousness and a broader

understanding of their role in society. The paramedical training programme was later amended and recast in the light of the experience and observations of paramedics and doctors. A complete curricula and education materials have been developed and compiled. The second batch of paramedics took six months to complete the training progran, which includes 2 weeks training in Cholera Research Laboratories, Dacca on Cholera and diarrhoeal diseases.

Altogether 31 paramedics have been trained. Each paramedic has been allocated 5-7 villages with approximately 5,000 people. He is required to visit each village once a week providing curative and preventive health services and supervise village based Family Planning workers.

In curative health the paramedics work consist of visiting each village once a week, making house to house calls and providing treatment to the sick people. The ailments beyond the paramedics competence are referred to medical officers in charge of three clinics operated in the project area. The paramedics have been trained on the diagnosis and treatment of 12 most common diseases and it is found that some 5% of those seeking care are in practice being referred to the doctors.

A consultation fee of Tk.0.50 was charged to the patient in addition to the cost of medicines. Average cost of treatment worked out at Tk2.50 to the patient. Despite this low cost, it was found that the poor half of the population could not afford to pay this. As a result, the average number of patients seen by a paramedic per day was only four. It was in response to this problen that BRAC developed a group Health Insurance Scheme.

The main features of the scheme are:

(1) A group consisting of at least 75% of the population of village with a minimum of 175 people can enter the scheme.

(2) Annual premium of 4 kgs., of paddy per person payable in advance.

(3) The insured must accept and cooperate in BRAC preventive health programme.

(4) BRAC to provide weekly paramedical curative health service to the group including referrals to doctors when necessary without further cost.

The programme was launched in May 1975. The paramedics and Field Motivators held group meetings in every village explaining the scheme. The organized village committees to collect premium from each family and handover the paddy collected from the whole group in one installment. It was hoped that in order to qualify for group insurance those who are better off in the community would pay the premium on behalf of those who could not pay. Although this has happened in a number of cases, the response has not been up to expectation. It is estimated that throughout the project 40-50% of the families were prepared to join the scheme but only 10% could master 75% coverage to qualify for group insurance. Only 37 groups covering 13,500 people had joined the scheme by July 1975. Since the insurance scheme runs from July to June no new groups are expected to enter the scheme this year.

Initially the paramedics faced a tremendous demand for treatment and drugs from the insured groups. The demand had gradually over a period of six months declined subsequently to a reasonable level. The villagers not insured can still receive curative service from the paramedic for a payment higher than those charged previously. Treatment free of charge is provided at the Area Managers recommendation to those who are extremely poor.

Mother and Child Health Programme originally planned for implementation through MCH clinics was organized through a village based 'Mothers Club' programme. 73 mothers' clubs have so far been organized in villages throughout the project area. Pregnant and lactating mothers attend club one day in a month in the village Gonokendra or other suitable places where the paramedics provide MCH services. The services presently include blood pressure checks, Iron and Vitanin supplements for pregnant mothers. All children are weighed in Salter Scale and their weights are recorded

in their "Road to Health Card". At the end, in a health education session of half a hour the paramedic conducts a discussion on nutrition, child care, prenatal health, family planning etc., using posters and other audio visual aids.

Primary vaccination is given to all children. DPT and BCG are now on order and all children under five years of age will be covered. It has also been planned to cover all pregnant mothers with Tetenus Toxoid.

In addition to the health education being imparted at the mothers clubs paramedics are regularly discussing health issues in primary schools, cooperative society meetingsand other gatherings. A new set of visual aids for use in health education is being developed at the BRAC Head Office in Dacca.

Due to the high incidence of Tuberculosis in the project area, BRAC is now developing a TB Control Programme. Paramedics have been instructed to locate confirmed and suspected T.B. cases in their units. Treatment is being provided free of charge to patients and community participation in the detection and control of TB is being elicited.

Although it is coming under increasing attention and scrutiny of national and international health planners BRAC still considers this programme to be in the development stage. New ideas and strategies will be introduced in Phase III to make this programme self supporting and self financing.

FAMILY PLANNING:

BRAC family planning programme centres round the village based female workers called the Lady Family Planning Organizer (LFPO). She receives one weeks initial training and frequent refresher courses for developing her skill as a family planning worker. She is supervised and supported by the paramedic in charge of her village.

A total of 110 LFPOs have been trained of which 87 are now working in their home villages. The LFPO's functions consists

of registration of all couples of child bearing age in her area of operation (500-700) couple; house to house motivation for enrolling family planning clients; regular delivery of contraceptive supplies and follow-up of her clients; seeking services of paramedic in case of complications and side effects; referral of clients wishing to have IUD, tubal ligation and vasectomy to one of the three BRAC clinics providing these services; collection and recording of data; organizing mothers club in her village and assisting the paramedic during club days.

An LFPO is paid Taka 30.00 per month and paid a bonus of Tk.0.50 per client over a base of 20 acceptors. Although LFPOs functions do require some amount of literacy, illiterate women who have been considered otherwise qualified have not been excluded.

Four doctors, 2 MBBS and 2 National Diploma holders, are empl in three Family Planning clinics providing sterilization and other supportive services. Although clinics have been equipped and docto trained for Tubal ligation, vasectomy and IUD insertion, Tubal ligation has not been offered during Phase II. This decision was taken in view of the fact that the husbands in male dominated socie wishing to avoid the much simpler procedure of vasectomy and preva upon their wives to underto tubal ligation. A campaign has been launched to enlist vasectomy clients and when a substantial number of couples requiring sterilization have been covered by vasectomy, tubal ligation will be offered.

The family planning programme started in January 1974 with the training of the first batch of 38 LFPOs. Since then successive batches have been trained and developed. Oral pills were found to be the most popular method of contraception and priority was given to oral pill distribution. Acceptors rose steadily month by month until a maximum of 2,105 clients was reached in May 1975. The numbe of acceptors seems to have reached a plateau with a slight decline

recorded during the following months. Problems were encountered when a switch had to be made from one brand of pills to another Combination 5 to Norylin. Combination 5 was considered by users to be better brand with few side effects. Despite Norylin's higher drop out rate, it was the only brand made available by the Government for distribution.

At the end of December 1975, 1,892 women in the project area were on pills, 38 had IUD inserted and 40 men have undergone vasectomy.

BRAC
SULLA PROJECT
PHASE - II

INCOME AND EXPENDITURE STATEMENT -
PERIOD: November 1, 1972 - December 31, 1975

	Taka	Taka
INCOME:		
Donation from:		
OXFAM, Oxford	2,220,588	
OXFAM, Canada	1,836,635	
		4,057,223
EXPENDITURE:		
Gonokendra	304,308	
Functional Education	428,825	
Cooperatives	400,831	
Agriculture	683,466	
Fisheries	132,460	
Training Programme	276,921	
Medical Care and Public Health	438,254	
Family Planning	367,371	
Programme Support		
Dacca	445,301	
Field	545,063	
Organisational Requirements	125,779	
	4,148,579	
LESS:		
Donations from housing Beneficiaries	293,271	3,855,308
Cash and Bank balances		201,915
		4,057,223

Report on BRAC Medical Programme
By
Dr. R. Arnholt, Oxfam Consultant

. Description of programme: Mostly available from BRAC publications - details of figures to be supplied by BRAC.
Briefly, an area of about 160 square miles of about 120,000 people in villages, completely rural setting, poor communications largely flooded annually during monsoon, rice growing.
BRAC started as relief agency then moved into development work.
Medical care is one part of the program.
Every village has the services of one of the 31 paramedics who are backed up by 4 doctors (2 MBBS, 2 "National doctors).
Paramedic training course by BRAC - to supply separate detailed description.
The paramedics offer:

a. Curative care for 12 most common disorders (see list)
b. A referral on other illness
c. Advice about hygiene, public health
d. Motivation and advice and referral for family planning
e. Supervision of family planning acceptors (eg. B/P check, elicitation of complaints, supervision of pill-taking in conjunction with the lady Family Planning Organizer LFPO).
f. Mothers' club supervision (talks, prenatal checks, prenatal vitamins, iron nutrition advice, young child weighing).
g. Immunization for pregnant mothers and for young children (still in planning stage).

All the above EXCEPT item a. are free to everyone. Item a. can be paid for in cash at Tk. 5 per consultation plus cost of medicines. With the Area Manager's permission indigents can be treated free of charge.
An INSURANCE scheme is available and encouraged: if at least 70% of a village participate, a village becomes insured for all curative care of the 12 disorders.
Separate families in uninsured villages can take out family insurance which entitles them to care only at one of the BRAC camps rather than at their village.
Insured villagers are covered in the village for all care that the paramedic can render them but may be referred to one of the doctors if he thinks they need it. Non referred patients are **not** accepted by the doctors except in emergencies.

All TB treatment is free but only given after the patient has been diagnosed in a Government facility (eg. X-ray or sputum report). The paramedic supervises the treatment prescribed by the doctor.
Every village in the area is assigned to one of the pm's. Most of them have 5 - 8 villages and all insured and many uninsured villages are visited weekly, some of the latter less frequently but regularly.
The cost of insurance (started July 1975) is 4 kg rice per year per family member. Newborns during the year will be covered; no refund is given for members who died or moved away. Disorders which BRAC does not treat are not covered.

2. Descriptive, iterpretative, explanatory comments offered by BRAC staff

Paramedic staff: Training - see sparate section.
Salary Tk. 225 - 300 monthly plus free housing in camp minus Tk. 100 for food consumed there
Most are from the local area - some actually practice in their village.
They keep a daily record of patients seen and treatment used, then weekly report, inventory, etc.
There are regular meetings, refresher days (monthly); Zonal meetings, which include non-medics; case discussions with MD.
Distance from MD not more then 14 miles.
The insurance scheme apparently arose in response t field staff desire to include poorer people in their care and from discussions in the field.
At present it covers only 10% of costs and 10% of population.
When it was begun, the use of drugs and the visits rose dramatically but now it has levelled off at a lower level again.

Figures: %of villagers seen per visit day:
3-4 before insurance
20-30 at beginning of scheme
5-10 now
About 10% of patients are referred by PM to MD.

Doctor: Stationed at one of the base camps. Has minimal facilities - though in one place can do delivery, has microscope. All have several drugs not available to PM.

Do vasectomies (program just starting)
Minimal administrative duties.
(PM's are under area manager.)
Supervise PM (medical only)
See referred patients (8 per day)
Out of office about 11 days per month.
Main function - teaching
one just finished a training course for PM for another program in Faridpur run by someone else.
MD would like more training in rural health
feels adequately trained for the usual emergencies including obstetrics.
Would like to know if the program can EVER be self - supporting.
Problem of visit to PM in field is that now the villagers want to see the Dr. when he comes.
Would like to have a female MD or FP specialist to handle some of the FP complications.
Plaster to care for simple fractures.
HOW does one include prevention in teaching program?
Would like to do more locally.

Observations:

I went together with the Assistant Field Director of Oxfam for a week's visit. A program was prepared so that I could see many parts of the activities. Most of the time we went together to the functions with several of BRAC staff (more than the 'normal' contingent). Some of the functions were scheduled at unusual times to accomodate our visit. Often we arrived too early or late for the function and people had to be called back or we had to forego the program. This was not anyone's fault but inherent in a brief visit to a widely dispersed population. After 3 days of these overview visits, I began to spend some time alone with the paramedics at work. I do not speak Bengali, the paramedics have varying knowledge of English - but sometimes a field motivator was along, at other times I could ask questions directly or later.
The BRAC field manual is written in English. The reports are usually filed in English though both languages can be used in entering items in the log sheet.

There is no prescribed way of carrying medications and it was interesting to see how widely the size of the 'bag' varied. Some carried all pills in small plastic bags or left over foil envelopes from the birth control pills, others took large stock containers. They all carried stethoscope and blood pressure cuff (one was out of order). These remarks apply to the 5 PM's whom I observed at various times (of a total of 31). I know one more with whom I have worked in a different setting.

They all seemed known and apparently accepted (as far as an outside can judge this) in the villages they visited. One visited his home village but it was not superficially apparent to me. 4 visits were insured villages, 1 to non-insured for family planning purposes. In 3 villages, the PM went to a specific building: 'gono kendra' - people's center in one, a school in another, and a farmer's house in a third. Usually he walked through the village first and thus his presence became known. People began to drift there, usually bri

their insurance card but sometimes without it - they were always required to fetch it though sometimes after being seen. Sometimes a messenger announced symptoms of someone at home and the PM went to the house. This occurred mainly with women patients but a number of them were seen at the exam site. Usually the PM listened to the complaint, sometimes asked a few additional questio then sometimes examined, then prescribed. The most variable part was the examination - it varied from patient to patient and among the PM's. The amount of talking also varied, reflecting the amount of advice given. There was no feeling of hurry, except that in two of the visits the schedule had been changed or delayed because of our visit. In one this resulted in the PM staying behind on his own because he did not want to leave anyone unattended.

The PM entered patient's name, card number, age, sex, symptoms, signs, diagnosis, treatment, with exact number of pills dispensed in his log book. He entered date of visit on the family insurance card and identified the family member seen by number. The pills were dispensed wrapped in old paper and oral instructions given usually in apparently fair detail. They were not always repeated by patient. Tetracycline appeared to be the most prescribed drug. In village A. PM actually had patient lie down on bench to examine abdomen when patient complained of abdominal pain. Some others did less. One man complained that he had spent Tk. 200 for private care because PM was not there (he was on leave) when he was ill. It was pointed out that a substitute was available and that a PM visited neighbouring villages and he could have sought help there.

Village B. had arranged to have drugs kept locally by the teacher. The PM wrote duplicate prescriptions and the teacher then dispensed the treatment after PM left. This was done to involve the village more in the care and in the drug use - partly in the hope, I believe, of enabling them to notice the amount of drug use. I noticed that the family of the teacher had 25 visits in the last 5 months- none by mother. The predominant number of men in the clinic was noted. There was one long discussion with brother of a man (patient not there) who is being treated for TB and who had differing opinion about need of injections from other practitioner. In village C. the PM had to move outside the people's center when the local youth organization held meeting. He continued outside in front of the building and interupted from time to time to visit someone at home - not always to do physical examination, but to talk to patient or her representative. He tended to prescribe both Tetra and Iodoquin for dysentery. He also gave triple sulfa for a small uncomplicated cut of finger. A common diagnosis was 'glossitis and stomatitis'. Several treated in absentia for these symptoms with vitamins.

In village D. The PM did not use one place but stopped at several locations in the village (a small one). At the first place, out in the open, we were offered small stools and then several patients (mostly chronic) came for Treatment. One complained of gastric symptoms of several years duration - it turned out that he had been referred to MD before, had had X-rays and had not consented to operation. He was again referred to Dr. TB patients' treatment was checked and discussed. After several patients had been seen, PM moved on to different site - stopped in some house. Thus he covered whole village, i.e. he did not actually go to each house door separately but was close to all and easily available to everyone.

Village E - noninsured large village - the PM met the LFPO (Lady Family Planning Organizer) and together with Field Motivator they visited the new 'acceptors'.

Blood pressure of each taken, brief discussion with husband or wife as to reasons for wanting family planning, then he gave pills to LFPO for giving to woman at the proper time. Old pill cards of previously started family planning patients were checked and dated to keep good track of use. One new patient was turned down because of high blood pressure and another refused to have her blood pressure checked in husband's absence. Of the old clients, only 3/23 came (said to be unusual) and about 2 new ones were seen.

We saw one malnourished child while walking through the village. Parent not there. Apparently child well until spring - measles then - diarrhoea since - uninsured, therefore no treatment but took name to discuss with area manager for permission to treat free. Another child with fever was brought to the PM and he treated and collected the fee.
The PM and Field Motivator then went to neighbouring village to meet the other PM. The latter still treated some local people and spent a rather long time with the village's 'big Man' whose family had multiple minor symptoms and required fairly long attention. It appeaes that this family requires several member visits nearly each week (20 visiting days are used, usually several pople from the family seen). Actually the PM recorded only those he treated, the ones who were examined but not treated did not get entered in the book. The Field Motivator had told me earlier that we were going to that village to meet the other PM and to do 'teamwork' and 'public health' but in fact nothing different took place. The PM with whom I had gone did help his colleague a little in preparing some items. The Field Motivators sat with us.

Opinions:

The basic health package offered by BRAC is consistent with the type of medical care available in developing countries. Its main component is the curative care of common conditions and this is supplied in the usual form of patient-medic interview and prescription, with some examination in some cases. The program does tend to allow more examination that many others but the main training of the PM is based on the history-prescription 'reflex'. In view of the types of diseases encountered this may be the only reasonable solution. It would be nice to have more emphasis on diagnosis - but even the most refined medical examination would result in a very tentative diagnosis in most cases - eg. diarrheal disease cannot be well categorized without laboratory examination. Treatment has to be based on probability. Physical examination can rule out some conditions, can alert the PM to other unexpected ones but mostly will be non-revealing. The exclusion of some treatable conditions may be its most important contribution.
The inclusion of 'preventive' care in the everyday work of the PM is more unusual and at least in theory a most vital and useful part. Actually that is not as widely practised as it sounds.

The discussion of the prevention of disease is included during the care of the sick patient by some of the PM's much more than by others (impression).
Separate health education is rare - but its value is unclear anyway.
The major preventive action of immunisation is planned but not yet implemented. Sanitation can only be discussed by PM, not much of it can be practised (though proper use of spoons in giving medicine and proper washing inbetween patients can be of both educative and actual value).
The close contact between villager and PM seems to be increased by door to door visits - particularly since they do not depend on the demand for service by the villager. The PM offers himself or his service by at least appearing near the door of the house. I do not know if this does have a different impact on the villager, if he is more or less likely to think of an ailment or to demand treatment with drugs. Superficially, it seems to me that this may foster a better relationship and a less intense need for the sign of 'care' shown by the giving of a drug. This is a speculation. It is of interest that one of the PM's did tell me that he thinks he would use LESS drugs if he went door to door than sitting at one place waiting for patients there. He cited the privacy and his ability to explain the disease and the lack of need for drugs for it. It may be that the visit BY the patient To the doctor requires MORE visible evidence of treatment than when the Dr. comes to the house and shows his concern directly in this way. No-one knows the answer; a controlled study is hard to set up (though it might be possible). However, this is one reason why it is desirable that BRAC should not change its mode of operation in all villages at once. No-one KNOWS how drug usage is affected by such factors and an attempt to decrease drug usage should be done on an experimental basis, ie. in some villages only. Use can then be monitored and conclusions drawn after a while.
Time consumed must, of course, also be taken into consideration and it may be that the 'centralization' of care is a great time saver in some villages. But it is the long run time that must be counted, not merely that per patient per day.
The availability of medicines in the local markets shows that this item is a source of income for traders, that people are spending money on medicines independent of diagnosis by a medical person. It appears, though I have no figures, that the total spent in this way is considerable. It also appears to me that the total impact of this money on the health of people is minimal. [illegible]

Will people spend less money if they are insured? Can this money be channelled into more productive uses? Would an alternative plan prepaying PM services but not including drugs be successful? This could be much cheaper - but would anyone subscribe? Could some of the costs be recovered by a small profit on the drugs? How much self-modication should be encouraged? (Cholera Research Leboratory is considering trying it out for diarrheal disease and BRAC could pioneer in one of its areas.) The use of drugs could be curtailed in the BRAC program. This would require a modification of the present manual of instructions and this is something that should not be done by an outsider. I think that even now, drugs are overprescribed both above the recommendations in the manual and that the manual encourages some excessive use. Unfortunately good evidence for my statement is not always available. Treatment of many of the conditions is not universally agreed upon. The stress to the PM should not merely be of the COST of the drugs but it must stress the fact that drugs can do HARM, that it is not always safer to treat than not to treat, that there are side-effects, etc. The continuous supervision of all staff is important to maintain quality of care and at the same time to stimulate interest in the job.

The doctors must continue to go out and actually see the PM at work even if this means that some patients will ask for their services directly. The PM may well work differently on the day of a doctor's visit - but he will not work less well. Therefore it is likely that he will give optimum performance on those days. If this is not up to the standards or expectations of BRAC then he does need help. But unless the doctor actually SEES the handling of patients and their complaints, he cannot know how the PM performs I feel that the most valuable part of my visit was the hours I spent sitting alongside the PM. No amount of talks or discussion could give me that information.

The doctors are welltrained. They can do some things for which they now do not have equipment and which would enable patients to benefit without extra travel. They should be equipped with a few things to carry out some of these functions. Only the staff can determine the details and it is understood that the doctors are not to spend most of their time in fancy curative care in their camps. But I would think that the facilities for dealing with obstructed labor, doing a spinal tap and looking at the fluid, dip sticks in urine or blood, scalpvein needles for infants hydration, setting uncomplicated fractures might be available.

The continuing education of PM and doctor is essential for morale and good performance. Too many PM programs train them, then let them swim all one. BRAC must continue to maintain refresher courses etc. Occasionally this may mean importing a guest or exporting a PM to another area, conference, hospital, rural program etc.

The Manual might be rewritten in Bengali for easier use by PM. At least some parts may be culled out and TABLES printed or written on thicker paper to be carried in bag (eg. amount of fluid needed for intravenous hydration of children of different ages. This would eliminate some of the need for calculation or thinking and possible serious errors). It would not require carrying the whole manual.

Review of the mixing of ' Oral solution' in light of the high water content of sugar and salt in this climate with Cholera Research Laboratory should be done. A vaccination program is possibly the most surely effective of known preventive programs. It should be implemented soon. It requires good planning for logistics. Thought must also be given to recording for the patient so that the patient has a record available at all times and of a fairly permanent nature. Otherwise it becomes a vague and possibly ineffective program and the same people have too many shots others none - esp ially as there may be OTHER agencies or Government eventually planning vaccinations in the area.

Can the insurance scheme ever be self-supporting? I do not know, but part of the answer may lie in the number of truly destitute people in the area who can never pay an insurance premium. If this number is large, it may mean that outside help is always needed. In the distant future, some of this may come from Government in the forms of subsidies or in kind in drugs or vaccines. This is probably remote and not reliable. For those that have adequate land, it is probable that insurance can cover the costs of salaries and ... , drugs,particularly if the drug use decreases for other reasons (see above) and if cheaper purchases are possible (see Echo story in Bangladesh Observer in October).

Can BRAC always depend on highly-motivated, selfless people? I rather suspect that the program would become more stable if PM became 'professionals' and may make it a career - but I know too little of local society to give a well-founded opinion. As an alternative it may be necessary to resurrect the idea of the village 'people's healer' who is less trained, cheaper, locally-based, does not require travel and can only deal with very simple situations. He (or she) can be supervised by a PM and in this way each PM can cover more villages and the program is more economical.

Suggestions (see also Opinion):

1. Continue insurance of some type.
2. If costs excessive, several ways MAY help to reduce them
   a. Decrease drug use (eg. Tetracycline, Paracetamol, cheaper purchases)
   b. Consider slight increase in number of villages per PM
   c. Gradually turn over more of family planning follow-up to LFPO to reduce PM load
3. Eforts to expand the population covered by insurance should be intense. Presumably a larger coverage would decrease costs per member.
4. Continued attempts to have destitutes supported by richer sec of village or to establish a savings scheme for them. (I know toolittle about structure of society to be firm about this.)
5. Field supervision at intervals of PM by doctors.
6. Brief annual educational experience outside the project for doctors.
7. Occasional outside experience for PM
8. Stress on physical examination by PM before prescribing.
9. Revision of Manual to decrease drug use (that is not the aim-the aim is better care and this would include decreased use).
10. Education of PM in his value as a diagnostician and evaluator rather than prescriber. If he becomes convinced of his value he can transmit this to the people.
11. Some widening of the preventive field and subjects (eg. inclu some accident prevention, case finding of TB contacts).
12. Attempts at Government contracts for some of the programs the Government does and conceivably could do more cheaply by usin established BRAC network and staff. I realize this is a very difficult area and possibly completely unrealistic.
13. Strong immunisation program.
14. Let women and PM's organize the women's clubs - too many othe organizations not to be involved.
15. Rewrite PM Manual in Bengali. Abstract some tables from it fo use in the field.
16. If better transport available, it could decrease PM time away from actual work. Geography may not permit this.
17. Stress proper labelling of drug containers. Although PM May r nize most of the drugs, the shape and size of the pills chang with different lots of different manufacturers. The potential serious error is greater with unlabelled containers.

18. Define clearly what insurance cover is and what it does.
19. Experiment with different systems of delivery, eg. door to door vs. gono kendra vs. camp clinic - but do not change all at once. Attempt some kind of controlled study in these matters.
20. Preventive work (eg. health education) requires some door to door work and it is the only way in which the PM can SEE what people are actually doing that can be corrected.
21. If Functional Education is effective, inclusion of discussion of health care and medical costs and financing should be helpful in exploring possibilities of insurance or selfhelp or home treatment.
22. Regular revision of PM Manual by project doctors, in consultation with others (eg. Cholers Lab., other paramedic programs)

A BRAC Paramedic talks on his work.

I Mr. Joynal is a Field worker of BRAC (Bangladesh Rural Advancement Committee) in Sullah Project - and responsible for particular 6 villages. My work is to motivate the people about family planning - health and education etc.

I visit all the villages once in a week. Out of 6 villages 3 has been insured and rest 3 is not been insure yet. I discuss about the problems with father mother and children. Those who are suffering with desease - I ask them first why they are suffering and what is the background. If I see they have no idea about the desease I give them suggestion to have always tubewell water and food should be neat and clean. If you follow these things I hope you can avoid the common deseases grow from above causes.

Family Planning:

I inform mothers about family planning that if you have more than 2 children you cannot provide them proper food and education. You will be suffer with desease with your child. So, apply family planning in your family and make happy family.

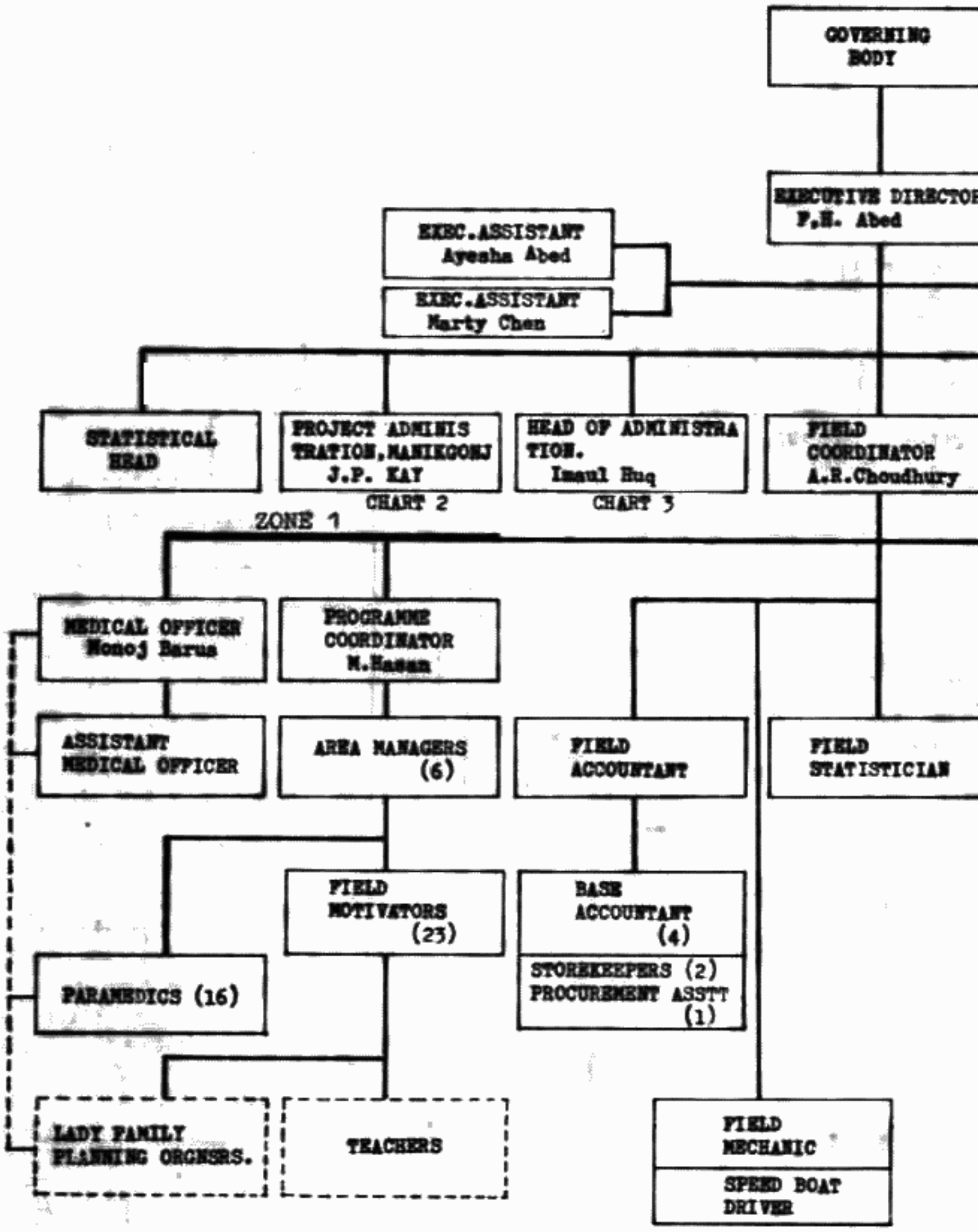
In which village there is no tubewell I suggest to have boiled water. Next time I check whether they are taking boiled water or not.

I check this in sperate way that is I tell them I am thirsty and could I have a glass of water? Then I can easily findout whether it is boiled water or not. Those families taking this suggestion they are getting good result and naturally the other families follow them. I also check whether any body sick in their house. If so tried to give preliminery treatment. If it is out of my reach I refer it to our medical officer. Firstly it is some difficult to motivate them - but when some of them motivated and getting good results then it is not difficult to motivate others. When every body understand the significant of suggestion we also feel happy to discuss with them more.

This is my openion that if any one wants to do anything he must need the energy and sincerity then he can reach the goal. Those who are taking pills I ask them whether they are taking in proper way or not. I can ask them any kind of question because I maintai very good relation with them. They do not feel hesitation to discuss with me properly.

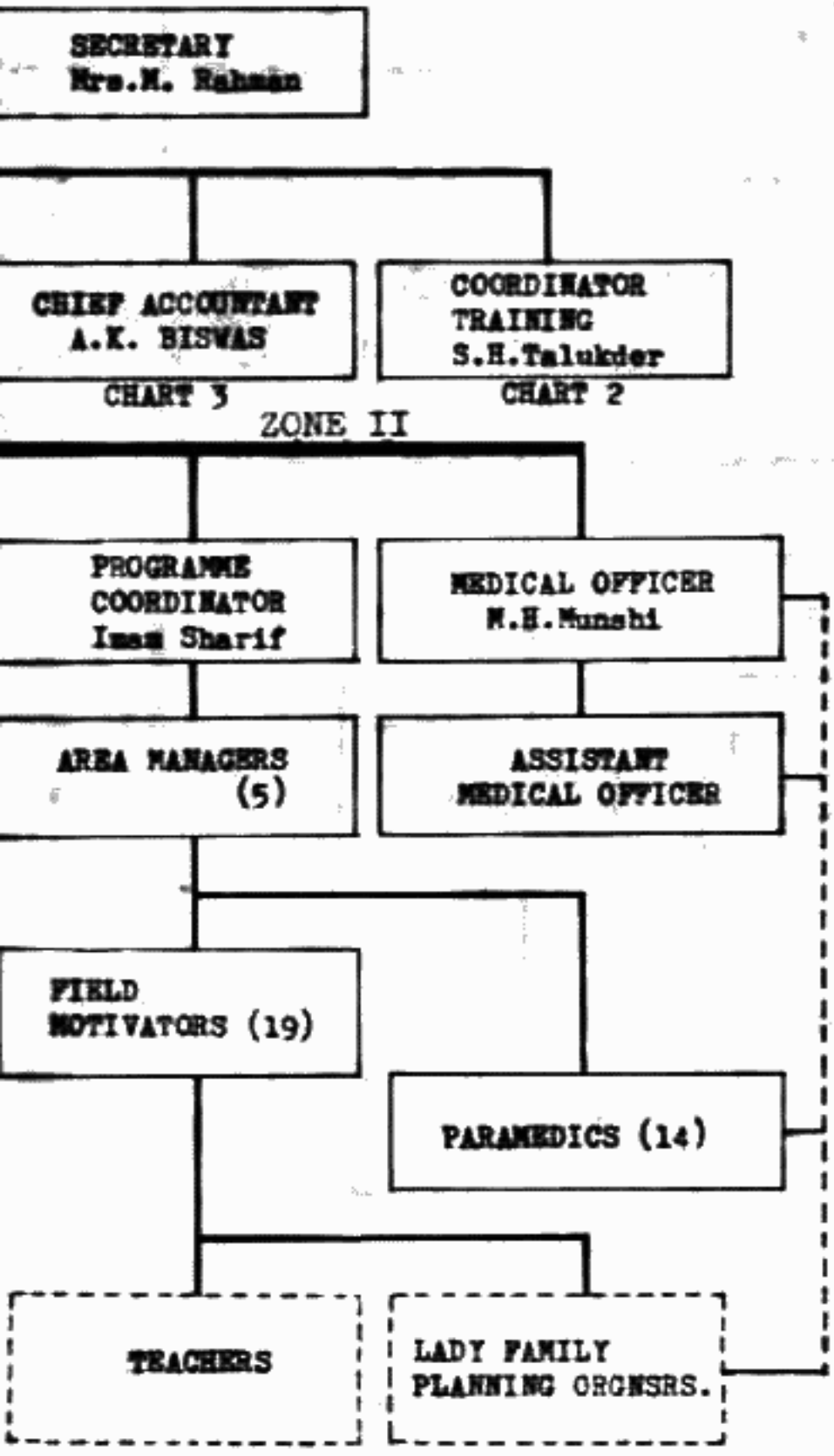
If any problem arise in the villages I discuss it with our area manager in the camp. By the routine work I visit villages and see the problems all day long. Of course this is my responsibility All the day I visit villages and back to camp. If anything difficult for me I discuss with our area manager find out solution and inform villagers next day. After sometime thw people of BRAC area will be happy because they are listening us. If the people happy we (BRAC people) also happy.

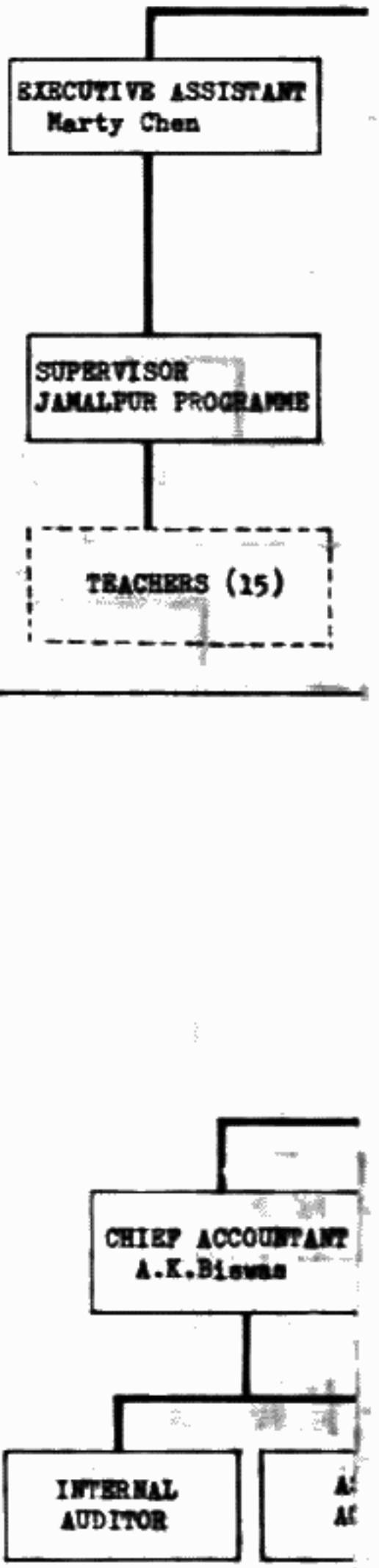
BANGLADESH RURAL ADVANCEMENT COM
ORGANISATION CHART - 1



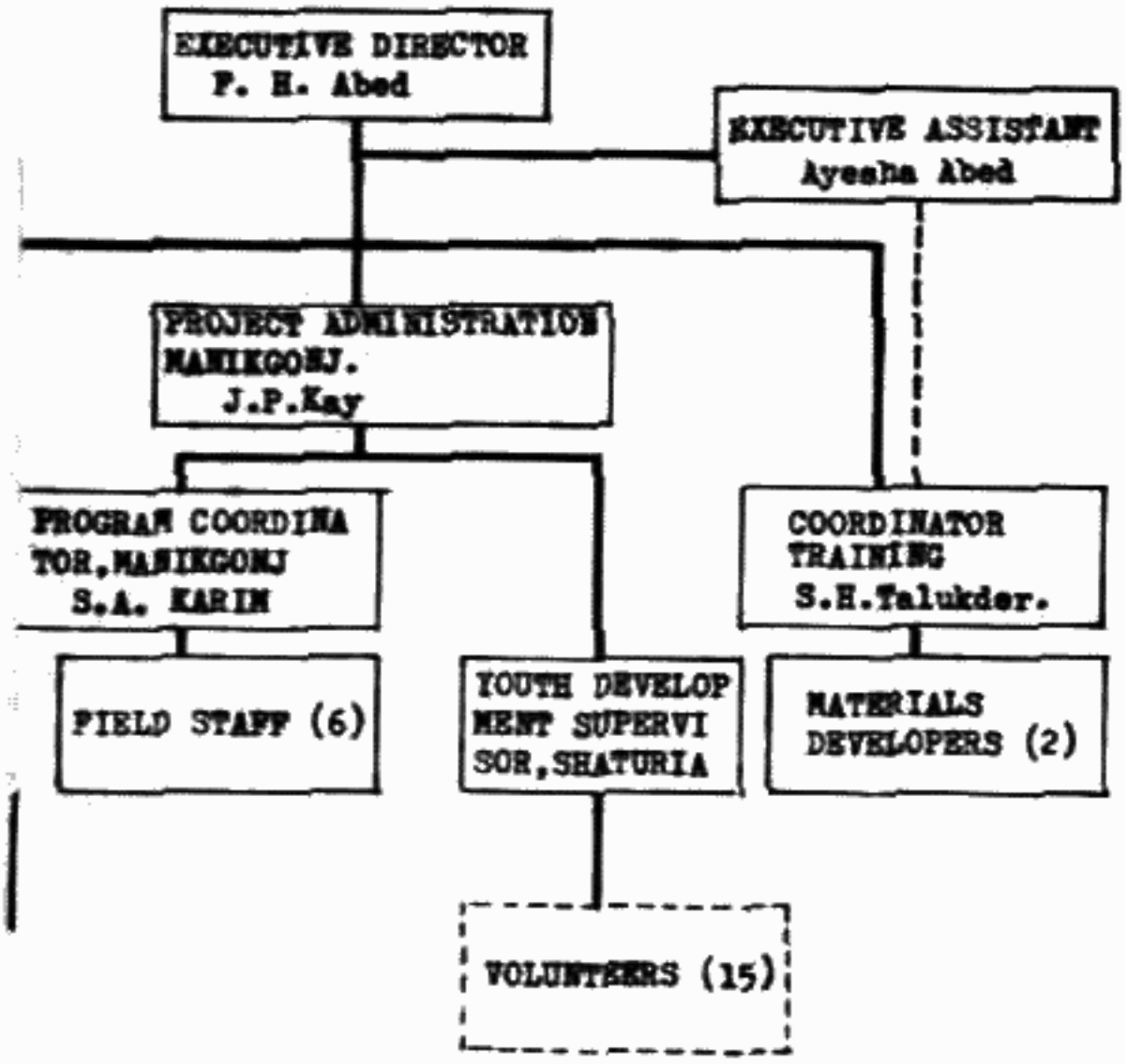
MEMBERS OF GOVERNING BODY
Begum Sufia Kamal - Chairman
Fazle Hasan Abed - Executive Director
Akbar Kabir
Habibuddin Ahmed
A.A.M.Imaul Huq

TTEE


SECRETARY
Mrs.M. Rahman
CHIEF ACCOUNTANT
A.K. BISWAS
CHART 3
COORDINATOR
TRAINING
S.H.Talukder
CHART 2
ZONE II
PROGRAMME
COORDINATOR
Imam Sharif
MEDICAL OFFICER
M.H.Munshi
AREA MANAGERS
(5)
ASSISTANT
MEDICAL OFFICER
FIELD
MOTIVATORS (19)
PARAMEDICS (14)
TEACHERS
LADY FAMILY
PLANNING ORGNSRS.


EXECUTIVE ASSISTANT
Marty Chen
SUPERVISOR
JAMALPUR PROGRAMME
TEACHERS (15)
CHIEF ACCOUNTANT
A.K.Biswas
INTERNAL
AUDITOR

BRAC
ORGANISATIONAL CHART - 2
OTHER PROJECTS



BRAC
ORGANISATIONAL CHART - 3
ADMINISTRATION